DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11038 (Rev. 06/03)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / ADULT MENTAL HEALTH DAY TREATMENT ATTACHMENT (PA/AMHDTA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the PA/AMHDTA Completion Instructions (HCF 11038A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)

2. Age — Recipient

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Requesting / Performing Provider

5. Requesting / Performing Provider's Medicaid Provider No.

6. Telephone Number — Requesting / Performing Provider

7. Name — Referring / Prescribing Provider

8. Referring / Prescribing Provider's Medicaid Provider No.

SECTION III — DOCUMENTATION

9. Number of hours per week requested

10. Estimated final treatment date

11. Has the recipient had previous adult mental health day treatment at the provider's facility or elsewhere?
❑ Yes ❑ No ❑ Unknown
If "Yes," list dates and locations.

12. Evaluation(s). Include date(s), tests used, and results.

Continued

SECTION III — DOCUMENTATION (Continued)

13. Attach page 1 of the recipient's most recent Functional Assessment Scales. (Functional Assessment must be signed and dated within three months of receipt by Wisconsin Medicaid.)

14. Is the recipient's intellectual functioning below average? ❑ Yes ❑ No
If "yes," what is the recipient's IQ score or intellectual functioning level, and how was this measured?

15. Provide a brief history pertinent to requested services (Include psycho-social history, hospitalization history, family history, living situation history, etc.).

16. Describe progress / status since treatment began or was last authorized, if applicable.

Continued

SECTION III — DOCUMENTATION (Continued)

17. Specify overall character of service to be provided.

❑ Rehabilitation ❑ Maintenance ❑ Stabilization

18. Identify measurable treatment goals.

19. Attach a specific schedule of activities, including date, time of day, length of session, and service to be provided.

20. Estimate the recipient's rehabilitation potential for employment (competitive, supported, sheltered, etc.), social interaction, and independent living.

Continued

SECTION III — DOCUMENTATION (Continued)

I have read the attached requests for PA of adult mental health day treatment services and agree that it will be sent to Wisconsin Medicaid for review.

21. **SIGNATURE** — Recipient or Representative	22. Date Signed
23. Relationship (if representative)	
24. **SIGNATURE** — Prescribing Physician	25. Date Signed
26. **SIGNATURE** — Therapist Providing Treatment	27. Date Signed
28. **SIGNATURE** — 51.42 Board Director / Designee	29. Date Signed

Reset Form